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Clinical Case Studies

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FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Single Age 16 years

CHIEF COMPLAINTS

Recurring attacks of severe diarrhea accompanied by hemorrhage from the bowels, weakness and anemia.

Recurring attacks of arthritis, associated with superficial ulcers of the skin.

PRESENT ILLNESS

Onset gradually about two and a half years ago (March 1927) when the patient began to be bothered with a moderate degree of diarrhea, the bowels moving two or three times daily. As far as he can recall there was no blood in the stools during this initial period but he was noticeably weak and pale. About six months after first noticing the tendency to diarrhea he developed an acute illness, ushered in by the passage of a large amount of dark red liquid blood when the bowels moved; during the succeeding three or four weeks he had frequent, severe hemorrhages from the bowels, a temperature from 100° to 101°, marked pallor, prostration and loss of weight. He then improved spontaneously and remained fairly well for about six months, when he again had a mild relapse, lasting about a week, with moderate diarrhea and the passage of small amounts of blood with the stools. In the spring of 1928, about a year after the onset, he developed, for the first time, a severe arthritis involving the knees, ankles, and toes, characterized by swelling, redness, and pain. A week later there developed sores on the extremities from the knees down. These sores are described as follows: The involved area first appears as a small round red spot, not raised, not tender and not burning, but apparently with a pin-point pustule in the center of it. In a few days the skin over the pustule drops off, leaving a deep sore under-

neath, "which looks as though it has black blood in it"; the ulcer is actively inflamed for about a week, resistant to treatment, burrowing deeper and enlarging in circumference. After 7 to 10 days healing occurs spontaneously, leaving deep, punched out, scarred areas. When these ulcers first appeared in March, 1928 he had about a dozen, varying somewhat in size and depth, the largest ones being over the left knee and the right toe joint, the smaller ones being scattered along the shins and outer aspects of both legs below the knees. He states that at no time were these painful or accompanied by other sensory disturbances.

After the attack of arthritis and ulcers had subsided, the patient remained quite well for the following year and a half, with the exception of a tendency to mild diarrhea, the bowels moving from two to four times daily, but without accompanying cramps. During these eighteen months of mild symptoms the bowel movements were soft or liquid, not large in amount, and did not seem to contain mucus or blood. He was active, a good color, and continued to go to school and take part in athletics.

Two weeks ago he again developed the arthritis involving particularly the toes and a few days later mild hemorrhages from the bowels appeared, since when he has been weak and pale, but otherwise normal.

The appetite and digestion have apparently been normal. The weight would go down during the more severe phases and be reestablished during the milder periods.

PAST HISTORY

Past history is negative up until the beginning of the present illness. He was always a very robust, active, rosy-cheeked boy, energetic and free from all acute or chronic illnesses. No acute infectious diseases in childhood.

Social history—patient is at present 16 years old, still goes to school, lives in the country, and enjoys all the normal athletic diversions of boyhood.

Family history—father and mother are living and well. Patient has one older brother, age 18, and one sister, age 3, both in good health.

PHYSICAL EXAMINATION

GENERAL

Height 64 inches Weight 92½ pounds Temperature 97.6°

The patient is thin, poorly nourished, pale, and there is a distinct yellowish tinge to the skin. No cyanosis, jaundice, or eruption. He seems mentally bright, alert and aside from the natural apprehension incident to the approaching examination, he does not seem mentally disturbed. His physical development is normal.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally and associated movements are normal. Mouth—teeth all normally erupted and developed. Gums are clean. Throat is rather pale, tonsillar tissue small and deep and no infected crypts can be seen. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—normal size; rate is 78, regular in force and rhythm. Sounds are all clear, no murmurs can be heard. Pulse—78, regular, no abnormal thickening of vessel wall.

ABDOMEN

Respiratory movements are normal. No masses can be felt and there are no areas of tenderness. Spleen is not felt; liver to costal margin, edge is not felt. No abnormal peristalsis.

EXTREMITIES

No edema. Reflexes are all normal. Both knees are slightly larger than normal, and there is a small amount of fluid in each knee joint, but no grating on motion and no tenderness. Scat-

tered over the lower legs from the knees down and over the toes one sees the scars of the former ulcers. No abnormal dilatation of the veins. Several scars of former ulcers can be seen over the ridge of the elbows. No tremor of the fingers.

BLOOD PRESSURE

115/70.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.

GENERAL HISTORY

White Male Married Age 50 years

CHIEF COMPLAINT

Enlargement of the spleen.

PRESENT ILLNESS

Patient's only complaint is of splenic enlargement. He noticed this himself by palpating the left upper abdomen and feeling the hard mass. For about a year he has been conscious of a feeling of fullness in the upper abdomen when he leans forward over his desk. This became much more noticeable during the past summer, and for a long time he attributed this to an increase in fat due to the taking of large amounts of milk. However, about two or three weeks ago he himself felt a hard mass projecting from under the left costal margin, and consulted a physician who confirmed the diagnosis of an enlargement of the spleen. Apparently there have been no subjective symptoms. There has been no change in weight, no feeling of weakness, and no digestive disturbances. No change in the character of the stools. No jaundice.

PAST HISTORY

Past history is essentially negative—always perfectly well. Never had any acute illness except pneumonia at the age of three, and has never suffered with any chronic complaint. Never had a headache in his life. All his life he has had the habit of belching after meals. He has developed the feeling that this belching "stirs up his stomach and aids digestion." His mother had the same habit and he probably originally developed it as the result of imitation. Never had any glandular enlargement, night sweats, or spitting of blood.

Habits—rather sedentary. He is a chemist in charge of a laboratory in a steel mill, and is exposed to all kinds of fumes. In this laboratory there are always a large number of open flames and he feels at times a sense of drowsiness which he attributes to deficiency of oxygen. Tobacco—one or two cigarettes daily. Alcohol—practically never.

Marital history—married 28 years. One child was born 26 years ago, died at 18 months of scarlet fever. Wife is living and well, no miscarriages.

Venereal history—entirely negative.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 68½ inches Weight 169¼ pounds Temperature 99.4°

Patient is well developed, well nourished. Skin is clear; no cyanosis, jaundice or eruption. Patient is not abnormally high colored, nor is there any flushing of his face. He does not appear unduly introspective. No evident dyspnea.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally and associated movements are normal. Mouth—teeth show numerous gold crowns. Gums show moderate pyorrhea. Throat is not injected; no tonsillar tissue is seen. Glands—no general enlargement; cervicals are not palpable; no glands felt about the clavicles. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—normal size; rate is 96, regular in force and rhythm. Sounds are rather distant, soft, and no murmurs were heard. Pulse—96, regular. No abnormal thickening of vessel wall.

ABDOMEN

There is no evident distention of the abdomen; no dilatation of the veins. Respiratory movements of the abdomen are normal. On palpation in the upper abdomen there is moderate enlargement of the spleen, this projecting down from under the costal margin, and descending only moderately with inspiration as though there were some fixation of the spleen to the diaphragm. The spleen is unusually hard and somewhat irregular, as though nodular. The liver is likewise moderately enlarged. It descends during inspiration and is not tender. It reaches about three fingers' breadth below the costal margin in the right

mammillary line and four fingers' breadth below the xyphoid in the midline. In the midline there is a suggestion of some irregularity, but it is not abnormally hard. There are no signs of free fluid in the abdomen. Palpation over the lower abdomen is entirely negative.

EXTREMITIES

No edema; reflexes are all normal; no tremor.

BLOOD PRESSURE

115/80.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.